A model for direct entry midwifery education and deployment in Ethiopia: Transforming rural communities and health care to save lives

Annette Maree Bennett

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Faculty of Health
University of Technology, Sydney
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CERTIFICATE OF AUTHORSHIP/ORIGINALITY

I certify that the work in this thesis has not previously been submitted for a degree nor has it been submitted as part of requirements for a degree except as fully acknowledged within the text.

I also certify that the thesis has been written by me. Any help I have had in my research work and in the preparation of the thesis itself has been acknowledged. In addition, I certify that all the information sources and literature used are indicated in the thesis.

Signature of Candidate

Annette Maree Bennett

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TABLE OF CONTENTS

ABSTRACT

Background: In Ethiopia, a landlocked country in the horn of Africa, only 10% of women give birth with a skilled attendant and the health workforce meets an estimated maternal and reproductive need of only 32%. Midwives save lives, however most midwives live in cities, while 83% of the Ethiopian population live in rural areas. There is therefore an urgent need to scale up the number of midwives and deploy them where they are needed. The aim of this study was to examine the outcomes of a new midwifery educational and rural deployment model which was implemented at the Hamlin College of Midwives in Ethiopia.

Methods: A mixed methods design was used to investigate stakeholder experiences and associated health service and outcome data. A thematic analysis of qualitative semi structured interviews with students, new graduates and staff members of the College was undertaken. A descriptive analysis of selected health service data was also undertaken before and after the deployment of Hamlin midwives.

Results: Three major themes emerged from the analysis. These are: the journey to midwifery; becoming a midwife; and innovation and transformation These themes revealed the challenges in accessing and pursuing education for rural girls, the transition academically, culturally and socially for midwifery students from rural areas, the passage of 'novice to professional' midwife as well as the emergence of professional midwives who are innovative and passionate advocates for women's health within their own communities.

Conclusion: Midwives who are recruited from rural areas, educated to fulfil the international competencies, thoughtfully deployed, supported and enabled with resources and referral networks can provide highly skilled, culturally sensitive woman centred care. Maternal health service usage and community engagement can be enhanced by the employment of local midwives who not only provide an important service but can be an agent of change through their action as a role model for girls, young women and their communities.

ABBREVIATIONS

Antenatal Care	ANC
Basic Emergency Obstetric Care	BEmOC
Evidence Based Practice	EBP
Ethiopian Federal Ministry of Health	EFMOH
Ethiopian Federal Ministry of Education	EFMOE
Emergency Obstetric Care	EmOC
Ethiopian Midwives Association	EMA
Higher Education Institution	HEI
High Income Country	HIC
International Confederation of Midwives	ICM
Intimate Partner Violence	IPV
Low Income Country	LIC
Millennium Development Goal	MDG
Maternal Mortality Rate	MMR
Midwives	Mw
Post-Partum Haemorrhage	PPH
Skilled birth Attendant	SBA
State of the Worlds Midwifery Report	SOWMy
Traditional Birth Attendant	TBA
United Nations Population Fund	UNFPA
World Health Organization	WHO

TABLES

Table 1: A comparison of the health status of woman in Ethiopia and Australia 27
Table 2:Literature review inclusion and exclusion criteria 48
Table 3: Participant Characteristics 77
Table 4: Demographic information.....165
Table 5:Family Planning activity from 2009-2010 and 2010-2011 167
Table 6: Health Centre Antenatal activity from 2009-2010 and 2010-2011 170
Table 7: Summary table for labour and birth activity from 2009-2010 and 2010-2011 172
Table 8: A summary of percentage changes for family planning, antenatal care and births managed in the health centre 173
Table 9: Key areas for discussion 179

FIGURES

PREFACE: A VISIT TO A HEALTH CENTRE IN RURAL ETHIOPIA

The dust billowed from under the 4WD filling the cabin and our lungs as it negotiated its way along the pot-holed road. Our destination was a small village in the semi-arid and mountainous area of northern Ethiopia. Local health officials were accompanying us on a visit to assess the maternal health work in a rural health centre. Occasionally, we passed farming families walking to the weekly market; the women, donkeys and camels laden with produce and wood. At one point, our capable driver miraculously squeezed past an enormous boulder that had come to rest in the middle of the road, having recently rolled from higher up the mountain.

The new health centre stood out in the ancient village of stone tukals (traditional house). The young midwife, Alemnesh* greeted us and explained that a woman had given birth less than two hours previously. My midwife colleague and I asked if we could be of any assistance and permission was given by the new mother for us to enter the delivery room. We were encouraged to see the midwife assisting Mary* to breast feed her baby but confused to find her still lying on the very narrow delivery 'couch' and not on the more comfortable 'postnatal bed'. Alemnesh explained to us that at 34 years of age Mary was an 'old primip' and she feared that she would have a postpartum Haemorrhage (PPH) – because of this, Alemnesh had instructed Mary to lie flat with her legs crossed as she had been taught by an older nurse in the health centre. Despite her fear Alemnesh had not however examined the placenta, palpated Mary's uterus, checked her blood pressure, pulse, her blood loss or assisted Mary to empty her bladder, all of which are normal practice. Alemnesh's fear was compounded by not having many resources such as essential drugs, intravenous fluids or a means of transporting a woman in an emergency.

We gently worked together carrying out a full postnatal check and assisting Mary off the 'couch' to empty her bladder and wash. We discussed the normal postnatal physiological process and management along with the risk factors, signs and symptoms of a PPH. It was a privilege to work alongside Alemnesh and to witness her genuine care and concern for Mary and Mary's baby. Alemnesh had a passion for midwifery, the women of the area and was keen to learn and to share her own experiences.

Alemnesh explained that she felt anxious and stressed each time a woman came to the health centre as there had not been much work and she still lacked confidence with her skills. She also explained that as a student she had very little clinical instruction or experience and like many of her peers had graduated and was registered after having assisted with only two births. Alemnesh was not from the area where she was assigned and did not speak the local language; she felt that traditional belief's, a lack of trust in her as an outsider and in modern medicine in general, prevented many women from coming to the health centre.

When it came time to leave, crying Alemnesh explained that this had been the first time since her graduation that she had worked with colleagues and she asked when we would come back to visit and work with her again.

Some months later we learnt that Alemnesh did not finish her 'service' in the health centre and like so many health workers in rural areas she moved to a city closer to family. Sadly the health centre was left without a midwife for more than a year after her departure.

*Names have been changed.

A personal account from a visit to a rural area in northern Ethiopia 2008

Note: Alemnesh was not a graduate from the Hamlin College of Midwives